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ABSTRACT

This guide provides background information to help interpret Iowa state and federal rules as they apply to physical therapy (PT) for students with disabilities (birth to age 21) in educational settings. The first section defines professional personnel requirements and statements of licensure for the positions of physical therapist and physical therapist assistant. The second section describes service delivery, addressing standards and guidelines for teaming; identification (screening, referral for PT assessment, PT assessment areas, and determining need for PT services); Individualized Family Service Plan development; Individualized Educational Program development (the IEP team, process, and components, and the delivery method for PT service); guidelines for determining the model and amount of PT service; and PT exit criteria. The third section addresses administrative considerations such as recruitment, employment, and retention of physical therapists; orientation of new staff; workload considerations; equipment and space; documentation; supervision and evaluation; continuing education and staff development; interagency collaboration; and liability. Appendices include a sample form for recording PT entrance and exit criteria; several models of PT service delivery; and a list of factors to consider when deciding on amount of PT service. (DB)

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Iowa Guidelines for Educationally Related Physical Therapy Services

EC 305285

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INTRODUCTION

In 1975, Congress enacted Public Law 94-142, The Education of All Handicapped Children Act which, in conjunction with the Iowa Special Education law, provided the foundation for education of all handicapped children, provision of services, rights to due process, and equal protection. This legislation mandated a free and appropriate public education, including support services such as physical therapy, to assist the child with a disability to benefit from special education.

Although physical therapists have provided services in public and private schools throughout the history of their profession, The Individuals with Disabilities Education Act (IDEA, Public Law 101-476, previously P.L. 94-142 and P.L. 99-457) and Section 504 of the Rehabilitation Act of 1973 have broadened the role of therapists and increased the demand for employment of therapists and assistants throughout the state and the nation.

The purpose of this document is to provide general background information and to help interpret state and federal rules as they apply to physical therapy in educational settings. Therapists, parents, and administrators across the state of Iowa had input throughout the development and revision process of the initial document. This document is intended to serve as a guideline so that each area education agency (AEA) employing therapists can establish or update specific agency guidelines for providing these support services to students (birth to 21 years) in special education.

Inherent in this document are the following assumptions:

1. Individuals eligible for special education should be served in the least restrictive educational environment possible. Infants and toddlers should be served in natural environments.

2. The educational relevance of an activity is defined by the educational curriculum and educational needs of the student.

3. The educational environment is the location where a student's curriculum is being implemented. For example, the educational environment of an infant may be the home; for a school-aged student it would be the school and surrounding grounds; and for a student with prevocational or vocational goals, it may include the community.

4. Motor functioning is an area which may be assessed by various disciplines (e.g., occupational therapists, psychologists, early childhood teachers and physical education teachers). Physical therapists assess motor functioning from their unique perspective.

5. Even though services may overlap, physical therapy and occupational therapy are separate disciplines with separate entry-level educational experiences and separate licensure laws.

6. Physical therapy and occupational therapy should both be available to students in special education as needed. Equal availability of therapies is assumed.

DEFINITION: PHYSICAL THERAPIST

Physical Therapy Licensure

A physical therapist (PT) is a person licensed by the Iowa State Board of Physical and Occupational Therapy Examiners who treats "human ailments by physical therapy" [§148A.2(1), 1993 Iowa Code]. The Iowa Physical Therapy Practice Act defines physical therapy as:

> that branch of science that deals with the evaluation and treatment of human capabilities and impairments. Physical therapy uses the effective properties of physical agents including, but not limited to, mechanical devices, heat, cold, air, light, water, electricity, and sound, therapeutic exercises, and rehabilitative procedures to prevent, correct, minimize, or alleviate a physical impairment. Physical therapy includes the interpretation of performances, tests, and measurements, the establishment and modification of physical therapy programs, treatment planning, consultative services, instructions to the patients, and the administration and supervision attendant to physical therapy facilities. Physical therapy evaluation and treatment may be rendered by a physical therapist with or without a referral from a physician, podiatrist, dentist, or chiropractor, except that a hospital may require that physical therapy evaluation and treatment provided in the hospital shall be done only upon prior review by and authorization of a member of the hospital's medical staff.

Statement of Professional Recognition

Special education personnel shall meet the Board of Educational Examiners requirements for the position for which they are employed. For physical therapists working in educational environments, this involves meeting the requirement for a statement of professional recognition (SPR).

As stated in Educational Examiners[282]—Chapter 15, Requirements for Special Education Endorsements, January 1, 1996:

> §282—15.3(13) *School physical therapist.*
>
> a. *Authorization.* The holder of this authorization can serve as a school physical therapist to pupils with physical impairments from birth to 21 (and to a maximum allowable age in accord with Iowa Code section 281.8). The legalization for this support personnel is through a statement of professional recognition (SPR) and not through teacher licensure.
>
> b. *Program requirements.*
> (1) Degree or equivalent baccalaureate in physical therapy.
> (2) Hold a valid license to practice physical therapy in Iowa as granted by the division of licensure, Iowa Department of Public Health. Procedure for acquiring a statement of professional recognition (SPR): The special education director (or designee) of the area education agency must submit a letter to the board of educational examiners, licensure bureau, requesting that the authorization be issued. Additionally, these documents must be submitted:

1. A copy of a temporary or regular license from the division of licensure.
2. An official transcript. A temporary SPR will then be issued for one school year if the class of license from the Department of Public Health is temporary.
3. A regular SPR will then be issued with verification of a regular license and at least a bachelor's degree in physical therapy.

Iowa Department of Education Rules

According to the *Rules of Special Education* [Education[281]—§41.9(3)"g," Iowa Administrative Code] a physical therapist "is a licensed health professional who applies principles, methods and procedures for analysis of motor or sensorimotor functioning to determine the educational significance of motor or sensorimotor problems within, but not limited to, areas such as mobility and positioning in order to provide planning, coordination, and the implementation of intervention strategies and services for eligible individuals."

Comment

In the educational setting in Iowa, physical therapy is a support service. The physical therapist is a member of a multidisciplinary, educational team whose purpose is to determine eligibility and to develop an individualized education program (IEP) or individualized family service plan (IFSP) for the individual requiring special education services. The therapist utilizes his/her expertise to assist an eligible student meet his/her IEP or IFSP goals and objectives in the least restrictive educational setting. The physical therapist working in an educational environment is not responsible for the total rehabilitative or habilitative needs of each student. Other aspects of a student's adaptive functioning outside of the educational setting may be the responsibility of other professionals (e.g., hospital and/or private therapist).

DEFINITION: PHYSICAL THERAPIST ASSISTANT

Physical Therapist Assistant Licensure

The Iowa Physical Therapy Practice Act [Chapter 148A, Physical Therapy, Iowa Code] defines a licensed physical therapist assistant (PTA) as an individual who is:

> required to function under the direction and supervision of a licensed physical therapist to perform physical therapy procedures delegated and supervised by the licensed physical therapist in a manner consistent with the rules adopted by the board of physical and occupational therapy examiners. Selected and delegated tasks of physical therapist assistants may include, but are not limited to, therapeutic procedures and related tasks, routine operational functions, documentation of treatment progress, and the use of selected physical agents. The ability of the licensed physical therapist assistant to perform the selected and delegated tasks shall be assessed on an ongoing basis by the supervising physical therapist. The licensed physical therapist assistant shall not interpret referrals, perform initial evaluation or

reevaluations, initiate physical therapy treatment programs, change specified treatment programs, or discharge a patient from physical therapy services (§148A.6, Iowa Code).

The administrative rules, [Professional Licensure[645]—§200.20(8)"c"(1) to (8)] state that:

(1) Licensed physical therapist assistants may assist in providing physical therapy services under immediate telecommunicative supervision as long as cotreatments are rendered according to the frequency described in this section...
(3) Cotreatment must occur on the first visit in which the physical therapist assistant participates in the treatment of the patient and thereafter as deemed appropriate by the physical therapist. When a change of the supervising physical therapist or the physical therapist assistant occurs, a cotreatment is required on the first visit of the supervising therapist.
(4) When providing physical therapy services under the supervision of a physical therapist, the physical therapist assistant shall:

1. Provide physical therapy services only under the supervision of a physical therapist.
2. Consult the supervising physical therapist if procedures are believed not to be in the best interest of the patient or if the assistant does not possess the skills necessary to provide the procedures.
3. Provide treatment only after evaluation and development of a treatment plan by the physical therapist.
4. Gather data relating to the patient's disability, but not interpret the data as it pertains to the plan of care.
5. Refer inquiries that require interpretation of patient information to the physical therapist.
6. Communicate any change, or lack of change, which occurs in the patient's condition which may need the assessment of the physical therapist.

(5)...[When an individual is receiving physical therapy through an Iowa educational agency, the minimal frequency of cotreatment shall be once every] five visits or 30 calendar days....
(6) A physical therapist may be responsible for supervising only two physical therapist assistants at any one time. However, a physical therapist assistant can be supervised by any number of physical therapists. The names of the two physical therapist assistants for which a physical therapist has supervisory responsibility shall be provided at time of renewal and change in supervision to the board...
(8) ...Following are activities which must be performed by the physical therapist and cannot be delegated to any assistive personnel including a physical therapist assistant:

1. Interpretation of referrals.
2. Initial physical therapy evaluation and reevaluations.
3. Identification, determination or modification of patient problems, goals and care plans.
4. Final discharge evaluation and establishment of the discharge plan.

Iowa Department of Education Rules

According to the *Rules of Special Education* [Education[281—§41.10(2)"e," Iowa Administrative Code] the physical therapist assistant "is licensed to perform physical therapy procedures and related tasks that have been selected and delegated by the supervising physical therapist."

Comment

Whenever service is provided by a physical therapist assistant, both the supervising physical therapist and the physical therapist assistant should be identified as service personnel in the student's IEP or IFSP. The physical therapist shall maintain written records of all therapy programs. If a physical therapist assistant is supervised by someone other than a PT, then the services delivered by the PTA many not be identified as physical therapy.

OTHER PERSONNEL

In the educational setting, other personnel (i.e., teachers, parents, other support service personnel, motor technicians or programmers, paraprofessionals, classroom aides or associates, or volunteers) are called upon to implement activities which will enhance the student's motor and educational performance. Some of these activities may be delegated by the physical therapist. The types of activities which are delegated should not require the expertise of a therapist and should be appropriate for the educational environment. The therapist should maintain written records of delegated tasks, document training of the designated personnel, and monitor the student's performance. The Iowa physical therapy administrative rules, Professional Licensure[645]—§200.20(8)"d," state that:

> Care rendered by assistive personnel other than physical therapist assistants shall not be referred to as physical therapy unless:
>
> (1) The supervising physical therapist has physical participation in the patient's treatment, evaluation, or both, each treatment day.
>
> (2) The supervising physical therapist is available "on premises" at all times when care is being provided by non-licensed assistive personnel.
>
> (3) Documentation made in physical therapy records by unlicensed assistive personnel shall be cosigned by the supervising physical therapist.
>
> (4) The physical therapist provides periodical reevaluation of assistive personnel's performance in relation to the patient.

The activities which are performed by personnel, other than the licensed physical therapist or licensed physical therapist assistant, which do not meet the above conditions cannot be called physical therapy.

ROLE OF THE PHYSICAL THERAPIST IN THE EDUCATIONAL SETTING

Physical therapists are health professionals traditionally trained and employed in medical settings to evaluate, treat, restore function, and prevent disability. Their orientation toward evaluation and treatment is usually closely related to the medical needs of individuals. Employment in educational environments with infants, children, and youth often requires further training for the physical therapist to effectively provide educationally related services. Therapists need background in general human and behavioral development, pediatric treatment techniques, the design and use of assistive technology services and devices, parent-teacher-team collaborative consultation techniques, inter-agency collaboration, rules and regulations of special education, writing individualized education programs (IEPs) and individualized family service plans (IFSPs), etc.

Physical therapists working in educational environments provide services to assist students in benefiting from their educational program. Some of these students do not have an identified medical diagnosis or impairment. In Iowa, a medical referral is not a necessary prerequisite for an eligible individual to receive physical therapy services in educational settings. The student's capabilities and needs in relation to his/her present level of educational performance are the focus for identifying goals, objectives and services to promote function within the educational environment. However, pertinent medical and health information should be obtained and considered by the PT and other IEP or IFSP team members.

A student may have a medical diagnosis or impairment, identified by personnel in a medical facility, which does not interfere with his/her educational performance. The medical diagnosis, as well as any information from the medical community, may be considered by the IEP or IFSP team when appropriate. However, if the team determines that implementation of the student's educational goals and objectives does not require the resources of physical therapy, then the physical therapist providing services through an educational agency does not have an identified role in this situation. The student's family may pursue therapy services, such as private therapy, outside of the educational setting at their own expense. The team may provide information regarding outside therapy resources, at the family's request.

Other students may have a medical diagnosis which significantly affects their school performance. In this case, the student may require physical therapy services in both medical and educational settings. The role of the therapist in the educational setting would be to provide service to the student as identified on the IEP or IFSP as well as to communicate with medical personnel, including private or hospital-based therapists, involved with the student.

In the educational setting, the needs and demands placed on the student may change from year to year. Therefore, the IEP or IFSP team may decide that the role of the physical therapist and the amount and model of service may also need to be changed. The role of the physical therapist working in educational environments is to assist the student in benefiting from his/her educational program, not to meet the total medical needs of the student.

TEAMING

Federal and state laws identify several different kinds of teams: a multidisciplinary team, an individualized family service plan (IFSP) team, and an individualized education program (IEP) team. The role of the physical therapist as a member of any team is to work with other members to assist the student and his/her family to identify the student's priorities, strengths, and needs; to plan strategies and goals for educational performance; and to anticipate outcomes for the future. In addition to providing unique professional expertise, therapists can be a resource to the team by explaining aspects of a medical disability and the relationship of that disability to the student's expected educational performance, and by facilitating interagency coordination.

Both IFSP and the IEP teams use consensus decision making to identify a student's goals, objectives and services. A consensus is a general agreement, built on trusting relationships, and achieved informally by seeking similarities and combinations of opinion. Decisions should be based on collected data or present the opportunity for ongoing data collection. Consensus does not necessarily infer 100% agreement, but it does mean that each team member can live with the decision.

For infants and toddlers (birth through 2 years of age) physical therapists function as members of an early intervention evaluation and assessment team that is multidisciplinary, and typically interagency, in order to determine the need for early intervention services. The family is an integral part of this team. If a developmental delay is identified, the IFSP is formulated and includes a statement of the family's resources, priorities and concerns relating to enhancing the development of the child. Major outcomes expected to be achieved by the child and child's family are recorded and specific early intervention services (e.g., physical therapy, occupational therapy, speech pathology, audiology, special instruction) are identified. In some cases it may be appropriate for outside agencies to be identified as the service provider for physical therapy instead of, or in addition to, the education agency. A physical therapist may be identified to serve as the service coordinator if he/she represents the profession most relevant to the child's or family's needs.

For students 3 to 21 years of age physical therapists may function as members of the multidisciplinary team to determine if a student is eligible for special education services. Other members of the team may include, but are not limited to a teacher, occupational therapist, speech-language pathologist, school audiologist, school psychologist, school social worker, educational consultant, nurse, and school principal. If the student is eligible for special education service, then the IEP team is identified. The IEP team may include all the previously mentioned individuals along with the parents, and the student as appropriate. Each team is individualized according to the needs of the student. For students requiring physical therapy, the therapist should be part of the IEP team. When a student is receiving physical therapy support services only, the *Iowa Rules of Special Education* [Education[281—§41.62(1)"a," "b," "d," "e," and §41. 68, Iowa Administrative Code] state that the IEP team must include "the general education teacher" and "the special education support service specialist with knowledge in the area of need," as well as "a representative of the agency

who is qualified to provide or supervise the provision of special education, and who has the authority to commit resident LEA resources," "one or both of the individual's parents," and the "individual, if appropriate."

IDENTIFICATION

Screening

There has been an increasing emphasis on early recognition and referral for children exhibiting signs of developmental lags or deviations in performance. Screening may be described as the process of surveying large numbers of general or special education students to identify those who do not fall within normal ranges of development or performance, as suggested by a broad estimate of their behavior. Results of screening usually indicate those students whose performance is not within expectations, or for whom there is cause for concern and require further follow-up or evaluation. Early detection may provide intervention at a critical time in the child's life when it may be most helpful. Physical therapists may play a key role in district-wide and local school "child find" activities, but more typically therapists consult and provide inservice for other school personnel who regularly screen groups of general and special education students.

Screening may include, but is not limited to, the use of any of the following methods:

1. Review of written information (i.e., school and/or medical records, teacher notes).
2. Interview with teachers or parents.
3. Direct observation (i.e., checklists, a systematic comparison with peers).
4. Formal screening tools.

Following screening, the screener should utilize the local education agency's (LEA's) or area education agency's (AEA's) policies to pursue additional assistance for the student.

General Education Interventions

"Each LEA, in conjunction with the AEA, shall attempt to resolve the presenting problem or behaviors of concern in the general education environment" [Education[281]—§41.48(2), Iowa Administrative Code]. A typical LEA process might be the utilization of building-level teams to assist the general education teacher identify ways to solve a student's classroom problem. Physical therapists are usually not members of these teams but may be contacted by another AEA building representative. It is the responsibility of the area education agency PT to identify for the building-level team the types of concerns which might appropriately require their expertise. When the general education intervention

requires the expertise of AEA staff, PTs may be involved in a problem-solving process which includes measurable outcomes, data collection and decision making, and goal-directed interventions. The systematic problem-solving process including the use of systematic progress monitoring is described in the *Rules of Special Education* [Education[281]—§41.47(3), Iowa Administrative Code]. When infants or toddlers not requiring or ineligible for an IFSP have an identified concern, these interventions would be provided by the parents in the home environment with assistance from AEA early intervention staff. Each AEA determines the extent to which the physical therapy staff participate in these general education or home-based interventions.

Identification for Special Education

Each AEA is responsible for developing an identification process which includes active parent participation. "Whenever a general education intervention is not appropriate to the needs of the individual, the multidisciplinary team may determine that a full and individual evaluation shall be conducted" [Education[281]—§41.48(2), Iowa Administrative Code]. Physical therapists, following their AEA procedures, are members of this multidisciplinary team and participate in the full and individual evaluation when their expertise is needed. Specific AEA identification procedures will affect the assessment process and decisions.

Referral for Physical Therapy Assessment

Referrals to the PT as part of the full and individual evaluation are made by the multidisciplinary team when the infant, toddler, preschooler, or school-age student is being considered for special education services or at any time when an educational disability is suspected. The referral process should follow AEA procedures in accordance with state and federal statutes and regulations. The assessment should always focus on the problem(s) identified in student performance areas. To assure that all individuals needing services are assessed, and to guard against over-assessment, the educational team should keep in mind the effect of the student's problem on his/her educational program, and the ability of other professionals to perform the assessment. A referral for physical therapy is indicated when a problem is noted in a functional motor skill area such as mobility or positioning. Area education agency PTs should provide their educational teams with indicators for appropriate referral.

Assessment

Assessment, as defined in these Guidelines, refers to a systematic process of gathering and interpreting information when it is believed that an individual (birth to 21 years) may require special education services or when an individual is already receiving special education. This information is used both to determine eligibility for special education services and to identify appropriate services. Information from the assessment is used by the evaluating therapist and the rest of the IEP or IFSP team to identify the student's present level of educational performance, goals, objectives and effective interventions.

Assessment involves obtaining and interpreting data related to a previously identified educational problem. Data may be gathered through record reviews,

specific behavioral observations, interviews, the use of standardized tests, performance checklists, and other data collection procedures. It is assumed that some type of problem-solving activity has occurred prior to initiating an assessment request. It is important to include observations of performance in context and in settings in which the behavior naturally occurs. Information gathering should be coordinated with the family and other team members as appropriate.

It should be noted that standardized tests are not always used by physical therapists. In many instances, normative data do not exist for individuals being evaluated by therapists. The therapist is responsible and accountable for selecting appropriate assessment procedures that are designed to document developmental level, physical status, and motor function as they affect educational performance. While motor functioning is an area assessed by physical therapy, other disciplines may also be involved in these assessments. Motor functioning assessment should not be considered the sole responsibility of PT.

An assessment by a PT should consider information from each of the following three assessment areas: 1) developmental motor level, 2) neuromusculoskeletal status, and 3) functional motor skills; as they affect the student's ability to meet the demands of his/her educational program. The subareas listed under functional motor skills for physical therapy are the same as those included in the Physical Therapy Entrance and Exit Criteria Form (see Appendix A).

Assessment results must be documented according to AEA procedures.

Physical Therapy Assessment Areas

1. Developmental motor level
   NOTE: A standardized developmental motor level is used to identify a delay when determining eligibility for early intervention services.
   a. Gross motor
   b. Fine motor

2. Neuromusculoskeletal components (may include any of the following)
   a. Muscle tone
   b. Developmental reflexes
   c. Joint range of motion and joint mobility
   d. Static postural alignment
   e. Dynamic postural adjustments
   f. Movement quality and movement patterns
   g. Strength and endurance
   h. Static and dynamic balance
   i. Motor learning and planning
   j. General coordination
   k. Visual-motor integration
   l. Oral-motor control

3. Functional motor skills
   a. Mobility
      1. <u>Functional movement skills:</u> Assess the student's ability to move within and around the educationally related school,

home, and/or community environment. Assess all types of mobility (i.e., rolling, crawling, assisted or independent walking, wheelchair mobility).

2. Architectural accessibility: Assess architectural barriers within the student's educational environment including the home, school, and/or the community that prevent the student from benefiting from the educational program (i.e., ramps, stairs, curbs, heavy doors, rough ground).
3. Utilizing appropriate assistive devices: Assess the student's need for and use of assistive devices (i.e., walkers, wheelchairs, prosthetic and orthotic devices).
4. Transfers: Assess the student's ability to perform educationally related transfers (i.e., to and from desk, chair, toilet, floor, bus, cafeteria bench, car).

b. Positioning

1. Independent sitting, standing, etc.: Assess the student's ability to achieve and maintain these positions independently as required to benefit from his/her educational program.
2. Assisted alternative positions: Assess the student's need for alternative positions and/or assistive positioning devices within the educational environment (i.e., prone standers, side lyers, adapted tables and chairs).
3. Transportation: Assess the student's need for specialized and/or adaptive positioning during transportation.

Determining Eligibility for Special Education

Following a full and individual evaluation by an early intervention team or multidisciplinary team, parents are invited to a meeting to determine the need for special education services and, for infants and toddlers, early intervention services. "Children who are handicapped in obtaining an education" are those individuals with disabilities who are unable to receive educational benefit from the general education experience without the provision of special education and related services...they are referred to as an eligible individual." Each AEA's child find policy will identify the manner and extent categorical designations are used. Handicapping conditions as categorized in the state of Iowa include: autism, behaviorally disordered, communication disability, deaf-blindness, deafness, head injury, hearing impairment, learning disability, mental disability, multicategorical, multiple disabilities, orthopedic impairment, other health impairment, physical disability, severely disabled, and visual impairment including blindness [Education[281]—§41.5, Iowa Administrative Code]. AEAs may identify students as eligible for special education without designating a specific disability category when an alternative process, typically a systematic problem-solving process, has been outlined in their AEA plan [Education[281]—§41.22(1)"d"(1), Iowa Administrative Code]. Based on the decision of the multidisciplinary team, the AEA director certifies the individual's entitlement for special education.

IFSP Development

P.L. 102-119 (Part H of IDEA, previously P.L. 99-457) defines services for infants and toddlers birth through age two, inclusive, who need early intervention because they are experiencing developmental delays or have a diagnosed physical or mental condition that has a high probability of a resulting developmental delay. In Iowa developmental delay is defined as a delay of 25% or more in one or more of the following areas: cognitive development, physical development, language and speech development, psychosocial development or self-help skills. Early intervention services are an interagency endeavor among the Departments of Health, Human Services, and Education. Following referral and assessment procedures and identification of appropriate services, a written individualized family service plan (IFSP) must be developed by the IFSP team, which must include the parent or guardian. The IFSP must be reviewed once a year and documented updates made at least at 6 month intervals. The IFSP must be developed within 45 days after assessment; but, with parental consent, early intervention services may commence prior to the completion of the assessment. Because Iowa's special education services begin at birth for eligible individuals, infants and toddlers with an IFSP must also meet all the requirements for an IEP [Education [281]—§41.69, Iowa Administrative Code]. Title 20 USC §1477(d) requires that:

> The individualized family service plan shall be in writing and contain—
>
> (1) a statement of the infant's or toddler's present levels of physical development, cognitive development, communication development, social or emotional development, and adaptive development, based on acceptable objective criteria,
>
> (2) a statement of the family's resources, priorities, and concerns relating to enhancing the development of the family's infant or toddler with a disability,
>
> (3) a statement of the major outcomes expected to be achieved for the infant or toddler and the family, and the criteria, procedures, and timelines used to determine the degree to which progress toward achieving the outcomes is being made and whether modifications or revisions of the outcomes or services are necessary,
>
> (4) a statement of specific early intervention services necessary to meet the unique needs of the infant or toddler and the family, including the frequency, intensity, and the method of delivering services,
>
> (5) a statement of the natural environments in which early intervention services shall appropriately be provided,
>
> (6) the projected dates for initiation of services and the anticipated duration of such services,
>
> (7) the name of the case manager (hereafter in this subchapter referred to as the "service coordinator") from the profession most

immediately relevant to the infant's or toddler's or family's needs (or who is otherwise qualified to carry out all applicable responsibilities under this subchapter) who will be responsible for the implementation of the plan and coordination with other agencies and persons, and

(8) the steps to be taken supporting the transition of the toddler with a disability to services provided under subchapter II of this chapter to the extent such services are considered appropriate.

The Code of Federal Regulations (CFR 34 §303.340-346) provides additional clarification on the content of the IFSP, the requirements for development, review and evaluation of the plan and provisions for the transition of children age 3 years. "Eligible individuals who are two years of age and will reach the age of three during the school year, who are receiving FAPE, and do not require services from other agencies, may be served through an IEP" [Education[281]—§41.69, Iowa Administrative Code].

IFSP Meetings

If an infant or toddler is determined eligible for early intervention services under Part H, an initial IFSP must be developed within a 45 day time period [CFR 34 §303.321(e)]. IFSP meetings are to be held initially and then annually and must include the parent or parents of the child; other family members as requested by the parent (if feasible); an advocate (if requested by parent); the designated service coordinator; and persons directly involved in conducting the assessments; and, as appropriate persons who will providing services to the child or family [CFR 34 §303.343]. The family is an important member of the team and all members are dedicated to a family-focused approach in identifying outcomes for the child or family and the development of a service plan. In Iowa, infants and toddlers with an IFSP identifying the need for education services must also meet all of the federal and state requirements for an IEP. This is accomplished by adding student-specific goals and objectives to the IFSP.

The IEP Team

Following the decision of the multidisciplinary team that an individual has a disability and needs special education services, an individualized education program (IEP) is developed. As stated in the *Rules of Special Education* [Education[281]—§41.62(1)"a" - "f," Iowa Administrative Code], participants in the meeting shall include:

> A representative of the agency, other than the eligible individual's teacher, who is qualified to provide or supervise the provision of special education, and who has the authority to commit resident LEA resources...; the eligible individual's teacher,...for an individual who is receiving only special education support services other than speech-language services, the teacher would be the general education teacher, either the teacher or the agency representative shall be qualified in the area of the individual's education need; one or both of the individual's parents subject to rule 41.64; the individual, if appropriate; and other individuals at the discretion of the parent or agency.

Physical therapists are members of the IEP team when they have participated in a student's assessment or are already identified on the IEP as a support service provider. Decisions regarding an individual's IEP are made jointly by all members of the team at the IEP meeting. An IEP team meets at least annually to review and revise the IEP.

IEP Components

For a detailed description of the IEP process, PTs should refer to the *Iowa IEP Resource Manual.* According to the *Rules of Special Education* [Education[281]—§41.67(1)-(8), Iowa Administrative Code], the IEP shall include the following:

(1) Present levels of educational performance (PLEP).
(2) Annual goals, instructional objectives.
(3) Special education and participation in general education.
(4) Projected dates of services.
(5) Physical education.
(6) Criteria, evaluation and schedules.
(7) Transition planning.
(8) Graduation.

In Iowa, an eligible individual may receive support services without the need for special education instructional services. Support services are defined as "the specially designed instruction and activities which augment, supplement or support the educational program of eligible individuals" [Education[281]—§41.86, Iowa Administrative Code]. If an eligible individual requires only support services such as the services of a PT, then the IEP must satisfy all the above requirements and the "special education support service specialist with knowledge in the area of need shall have primary responsibility for recommending the need for support service, the type or model of service to be provided, and the amount of service to be provided...The special education support service provider shall attend the IEP meetings for the eligible individual being served" [Education[281]—§41.68, Iowa Administrative Code].

The IEP Process

At the IEP meeting the team, including the PT and parents, collaborate to 1) identify a present level of educational performance which states the student's needs; 2) determine the annual goals and at least two short-term objectives per goal directly related to these needs; 3) decide on the instructional, support, and related services needed as resources to help meet the student's goals and objectives; and 4) identify the appropriate educational placement in the least restrictive environment. The team also decides the amount of time necessary to meet the student's needs that is required from the following individuals, including but not limited to general and special education teacher, associate, parent, PT, PTA, or other personnel. Delegation of responsibilities to team members should also be identified and documented at the meeting. In addition to federal and

state IEP requirements, the IEP should include the following information specifically related to physical therapy:

1. Goals and objectives requiring the resources of a PT.
2. Model of physical therapy service.
3. Titles of personnel responsible for the service (Note: whenever PTA service is identified, the supervising PT must also be identified.).
4. Amount and duration of physcial therapy service.
5. Justification for the need for physical therapy services.

Identifying Physical Therapy as an IEP Resource

Following an assessment by a PT and identification of the eligible individual's goals and objectives, the evaluating therapist and the rest of the IEP team should consider the following entrance criteria. Physcial icerapy should be identified as a resource only when the PT's unique expertise is needed to meet an identified student's goals and/or objectives and when the absence of physical therapy would prevent a student from benefiting from his/her educational program. It is important that the goals for the student be identified before deciding that physical therapy is needed or before choosing a service model. "Because of their training, occupational and physical therapists are very good at devising ways to enhance a student's performance, but one must always consider if the expertise of the PT is necessary in order to assist the student in meeting specific educational outcomes" (Hanft, 1996).

Entrance Criteria

To consider physical therapy as a resource to assist in meeting a student's IEP or IFSP goals and objectives, **ALL** of the following criteria should be met in at least one behavior of concern or presenting problem area.

1. The problem interferes with the student's ability to participate in his/her educational program.
2. The problem appears to be primarily motor or sensorimotor based.
3. As documented, previous attempts to alleviate the problem have not been successful.
4. The therapist's unique expertise is required to meet the student's identified needs.
5. Potential for positive change in the student's problem as a result of intervention by physcial therapy or negative change without intervention appears likely. Change as a result of therapy should be in addition to changes due to the increasing age or general maturation of the student.

Therapists should assist the team to justify the student's need for the support service of physical therapy. To assist in decision making, a Physical

Therapy Entrance and Exit Criteria Form may be completed by the PT evaluating the student and should be specific to that evaluation. Sample forms are found in Appendix A.

Determining the Model of Physical Therapy Service

After a student's goals and objectives have been identified and physical therapy is deemed necessary, the evaluating therapist (along with the other IEP team members) should consider the following factors when choosing a service model: the least restrictive environment needed to accomplish the goals and objectives related to physical therapy service; the type of skills to be learned and the methods and strategies of intervention anticipated; the level of expertise required to provide the service; and the need for and availability of others to carry out the student's program (see Appendix B). A change in the model of service would constitute a change in the student's IEP and would, therefore, require another IEP meeting.

The *Rules of Special Education*, Education[281]—§41.86(1) Iowa Administrative Code, identify five support service delivery methods:

a. Cooperative efforts of special education support personnel and the general education teacher in the general education classroom to provide specially designed instruction and related activities.
b. Cooperative efforts of special education support personnel and special education teachers.
c. Provision of specially designed instruction by a special education support service provider in the general classroom or in an environment other than the general classroom.
d. Consultation with general education teachers and special education teachers, and may include the modification of the general education environment, curriculum, and instruction.
e. Provision of support services to an eligible individual through this individual's parents, teachers or others in the environment.

Physical therapy service delivery, as described in these Guidelines, utilizes all of these methods to create three models of physical therapy service.

The three physical therapy models of service are direct, integrated, and consultative. See Appendix B for a summary of considerations for service model selection. Each model has its own characteristics and benefits and the important decision is to match the model to the individual student's needs. These models are not hierarchical with regard to time commitments or benefit and decisions related to amount of service time are independent from the type of model chosen.

Direct Service Model

In a direct service model the therapist works with a student individually. Therapy may occur in an isolated environment due to the need for instruction free from distraction or the need for specialized equipment not found in the classroom setting. Typically, direct service is used when frequent program changes are needed and other personnel do not have the unique expertise to

make these decisions. It is the therapist's professional judgment that determines when a licensed therapist, or supervised licensed physical therapist assistant, is the only person uniquely qualified to carry out the therapy program. The therapist, or assistant under the supervision of the therapist, is the primary provider of service and is accountable for specific IFSP or IEP short-term objectives for the student.

The emphasis of direct therapy is usually on the acquisition of basic motor or sensorimotor patterns or sequences needed for new skill during a critical learning period. The student has not achieved a level of ability which would permit transfer of skills to other environments. Often only a short interval of direct service is needed before the student can participate in a less restrictive model of service. Intervention sessions may include the use of therapeutic techniques and/or specialized equipment which require the therapist's expertise and cannot safely be used by others within the student's educational environment. In the direct service model there is not an expectation that activities will be delegated to others and carried out between therapy sessions.

Integrated Service Model

Integrated therapy service is a model of service which combines direct student-therapist contact with collaborative consultation with others involved in the student's educational program. There is an emphasis placed on the need for practice of skills and problem solving in the student's daily routine. The process of goal achievement is shared between or among those involved with the student, including the therapist, therapist assistant, teacher, parents, classroom associate, and others in a collaborative manner.

Intervention includes adapting functional and meaningful activities typically occurring in the student's routine, creating opportunities for the student to practice new skills, and collaborative problem solving with others to encourage optimal functioning and independence. Only the actual time spent providing service by the therapist, or assistant under the supervision of a therapist, is considered therapy. Activities or follow-through performed by others cannot be called physical therapy. Integrated therapy service is provided within the student's daily educational environment and should always include others involved with the student who can carry out the delegated activities.

Consultative Service Model

Consultative physical therapy service is a model whereby the therapist participates in collaborative consultation with the teacher, other staff, parents, and when appropriate the student regarding student-specific issues as identified in the student's IFSP or IEP goals and objectives. The therapist's input is typically needed to determine appropriate expectations, environmental modifications, assistive technology, and possible learning strategies for the student. The therapist's unique expertise may also be needed for staff and parent training. However, the therapist's expertise is not required for student-specific interventions used to accomplish the IFSP or IEP goal and/or objective.

Physical therapy appears on the IFSP as an early intervention service or on the IEP as a support service and is associated with a specific IEP goal and/or

objective. Since the therapist is not the primary individual responsible for carrying out the interventions related to the goal and/or objective, at least one other instructional or support service provider is also identified. The time the therapist will spend in collaborative consultation appears on the IFSP or IEP.

Determining the Amount of Physical Therapy Service

As stated in the Code of Federal Regulations (34 CFR Part 300, Appendix C, Question 51):

> "The amount of services to be provided must be stated in the IEP, so that the level of the agency's commitment of resources will be clear to parents and other IEP team members. The amount of time to be committed to each of the various services to be provided must be:
>
> 1. Appropriate to that specific service, and
>
> 2. Stated in the IEP in a manner that is clear to all who are involved in both the development and implementation of the IEP."

Physical therapy literature or research has not mandated standards that would indicate that a certain type of motor problem requires a certain amount of service. The amount of service depends on numerous factors including the expected or documented potential for improvement with therapeutic intervention, the existence of a critical period for skill development, the amount of training needed by the person carrying out the program, and the amount the problem interferes with the student's educational program (refer to Appendix C). For complete instructions explaining the use of this form, refer to the *Resource Manual for Physical and Occupational Therapists*. Objective progress monitoring of student performance is necessary to determine if the amount of service is appropriate to promote progress toward attainment of the student's goals and objectives. Systematic progress or mastery monitoring procedures are recommended whenever possible. Changes in the amount of physical therapy service can only be made following a therapy reevaluation and resulting IFSP or IEP meeting.

THERAPY INTERVENTION

Physical therapy services must be provided in a manner consistent with what is documented on the student's IEP or the infant or toddler's IFSP. Physical therapy intervention procedures should be specific to each student's individual needs. The approach used should relate to the functional motor skills identified on the student's goals or short-term objectives. There are many different intervention philosophies and strategies which the therapist may choose to use. It is the responsibility of the therapist to be aware of currently accepted therapy procedures and to determine the best method to translate this knowledge into practice. Therapists should always strive to provide interventions in the natural or least restrictive environment for each individual receiving therapy. Data collection and progress-monitoring protocols should be used on a

frequent and consistent basis to document the effectiveness of the intervention procedures that were chosen and to make decisions regarding changes in interventions.

Transition planning is an important aspect of therapy intervention. Typical transitions occur between programs (i.e., early intervention services to preschool, elementary to middle school, secondary to graduation). It is important for the therapist to be involved at these critical transition periods as the student's needs may change, and it may be necessary to alter the model or amount of service to meet the student's needs, or perhaps discontinue services altogether. Often many students served as young children will again need therapy services as young adults transitioning to alternative living, higher education, and/or employment.

If a therapist is not trained in a specific area of intervention, outside consultative assistance should be considered. Ongoing staff development and continuing education goals should be identified so that therapists are qualified to meet the needs of the students they are serving.

DISCONTINUING PHYSICAL THERAPY SERVICES (EXIT CRITERIA)

When a student has completed or met **ONE** of the following criteria, the IEP team should consider exiting the student from therapy services. The Physical Therapy Entrance and Exit Criteria Form found in Appendix A may be used to assist in the decision-making process and can be useful when justifying the decision to change physical therapy service.

1. Goals requiring the unique expertise of a PT have been met or no longer need the unique expertise of a PT and the student has no additional goals and objectives that require the resources of physical therapy.

2. Potential for further change as a result of physical therapy intervention appears unlikely based on previous documented intervention attempts. Physical therapy is no longer the appropriate resource to meet the student's needs as identified through the IFSP or IEP goals and objectives.

3. The behavior of concern or presenting problem ceases to be educationally relevant.

4. Therapy is contraindicated due to change in medical or physical status.

There must be an IFSP or IEP meeting, appropriate team involvement in decision making, and parent notification to exit a student from services.

RECRUITMENT, EMPLOYMENT, AND RETENTION OF PHYSICAL THERAPISTS

Physical therapists available to work in AEAs have historically been in short supply. Active recruitment can be a time consuming but necessary activity. The *Rules of Special Education* [Education[281]—§41.20(1), Iowa Administrative Code] state that "Each AEA plan shall include a description of the procedures and activities the AEA will undertake to ensure an adequate supply of qualified personnel...including special education and related services personnel and leadership personnel. The procedures and activities shall include...a plan that:

a. Addresses current and projected...personnel needs...
b. Coordinates and facilitates efforts among the AEAs and LEAs, institutions of higher education, and professional associations to recruit, prepare, and retain qualified personnel, including personnel from minority backgrounds and personnel with disabilities."

One excellent opportunity to coordinate with institutions of higher education is to work collaboratively to provide affiliation experiences for student PTs and student PTAs. The PT Consultant at the Bureau of Special Education is available to assist with these efforts by supporting therapists and assistants as they function as clinical supervisors of therapy students, and by supplying institutions of higher education with information about working in AEAs and providing therapy services to individuals in special education.

According to the *Rules of Special Education* [Education[281]—§41.86, Iowa Administrative Code], "Support services are the specially designed instruction and activities which augment, supplement or support the educational program of eligible individuals. These services are usually provided by the AEA but may be provided by contractual agreement, subject to the approval of the board, by another qualified agency."

The following is a list of employment alternatives some AEAs have used:

1. Direct employment by:
   a. AEAs.
   b. individual school districts through a contract with an AEA.

2. Contract for physical therapy services with:
   a. public health agency.
   b. local rehabilitation facility or hospital.
   c. private practice PT.

Contracted therapists should be willing to make the transition to the provision of service in an educational environment and follow the *Iowa Guidelines for Educationally Related Physical Therapy Services*. The Iowa Department of Education PT Consultant is available to assist AEA supervisors and contracted therapists with this transition. To be educationally relevant, contracts should include time for travel to the educational setting, to evaluate and re-evaluate as necessary, to attend IEP or IFSP meetings, to provide the model and amount of service identified on the IEP or IFSP, to monitor and document

progress, and to meet with other team members, including parents, teachers, and other AEA staff. When contracts are written for only one-on-one services away from the educational setting, AEA personnel should be identified to act as a liaison to perform the other educationally relevant services needed by the student and his/her team.

Therapists have identified a variety of reasons they choose to work for an AEA. Some of these include flexible work schedule with a school system calendar, the challenge and enjoyment of working with children birth to 21 years, the autonomy of setting their own daily schedule, opportunity to work in other settings in the summer, and continuing education opportunities.

Factors contributing to long-term retention at an AEA have also been identified by therapists. These include adequate orientation and initial training, opportunities for mentoring by experienced therapists, ongoing professional development, manageable caseloads, appropriate supervision, opportunities for involvement in AEA-wide program development and/or personal development, autonomy matched to skill level, and competitive salary and benefits.

ORIENTATION OF NEW STAFF

In order to provide services which are appropriate and consistent with the educational system, the contract and direct-hire physical therapy staff must understand both the area education agency (AEA) and local education agency (LEA) systems' policies and procedures. The following areas should be included in the orientation of the physical therapy staff to the AEA and LEA:

1. Orient staff to the basic philosophy of physical therapy in an educational environment.

2. Provide new therapists with:
   a. information related to federal laws and regulations concerning general and special education including the Individuals with Disabilities Education Act, The Americans with Disabilities Act, The Rehabilitation Act, Section 504, and The Technology-Related Assistance for Individuals with Disabilities Act;
   b. a copy of the *Iowa Rules of Special Education;*
   c. a copy of the *Iowa Guidelines for Educationally Related Physical Therapy Services* (rev. 1996), the Iowa Department of Education, Bureau of Special Education *Resource Manual for Physical and Occupational Therapists* (1990, with current updates), and other resources available through the Bureau of Special Education PT Consultant;
   d. a copy of the previous therapist's summary of information concerning the students they will be serving;
   e. a schedule of staff development at the LEA, AEA, and state level; and
   f. other relevant forms, handbooks, and schedules.

3. Inform the physical therapy personnel of AEA and LEA procedures for:
   a. systematic problem solving and progress-monitoring activities for students in general and special education,
   b. the determination of need for special education and development of the IEP and IFSP,
   c. distribution and location of reports and IEP and IFSP documentation,
   e. requisitioning materials and equipment, and
   f. other relevant procedures.

4. Introduce the new physical therapy staff to:
   a. special education administrative and support staff,
   b. principals of schools serving students receiving their services,
   c. general and special education teachers and classroom associates as appropriate, and
   d. other AEA staff they will be working with.

5. Provide an opportunity for the PT and PTA to observe during home visits and in special and general education classrooms and observe other AEA therapists providing services to students.

6. Orient the PT and PTA to community resources relevant to students (birth to 21 years) with disabilities.

7. Identify other therapists and/or personnel who could serve as a mentor.

WORKLOAD CONSIDERATIONS

Each AEA plan must include "a description of procedures for monitoring the caseloads of ... AEA special education personnel to ensure that the IEPs of eligible individuals are able to be fully implemented" [Education[281]—§41.22(1)"a," Iowa Administrative Code]. A number of factors enter into the development of an individual therapist's schedule and caseload. Because of the variability of these factors, no definite caseload guidelines have been established. However, all activities expected of a therapist; including travel, office time, lunch and break times, and all of the activities identified below; should fit into a hypothetical, weekly or monthly "paper" schedule.

The following are workload factors influencing the number of individuals in special education that the PT can adequately serve on his/her caseload:

1. The number of PT assessments anticipated in an average month including time for information gathering; data collection; observations in educational environments; consultation with family, other AEA staff, and teachers; documentation of assessment; attendance at meetings to determine eligibility for special education and IFSP or IEP meetings.

2. The total amount of physical therapy service provided as identified on students' IEPs and IFSPs.

3. Supervision and training of physical therapist assistants.

4. The amount of travel time in a typical week or month. Itinerant therapists, serving schools that are widely separated geographically, not only spend time traveling but also organizing when they arrive.

5. The amount of LEA and AEA staff and parent collaborative consultation and training that is not identified on a specific student's IFSP or IEP.

6. The amount of time spent in general education systematic problem solving and progress-monitoring activities.

7. Training of students from physical therapy, early childhood, or special education institutions of higher education programs.

8 Other responsibilities including:
a. participation in staff development,
b. administrative duties, and
c. team and committee meetings.

9. Availability of secretarial and other support assistance.

10. The experience and training of the PT.

EQUIPMENT AND SPACE

Funds should be available to the PT for specialized equipment and materials which are required to perform assessments and trial intervention sessions. Therapists should be consulted for input on the type of equipment to be ordered. Needed equipment may include the following:

1. Positioning materials such as wedges, bolsters, feeder seats, prone standers, adapted tables or chairs.

2. Therapeutic equipment such as walkers, crutches, scooter toys, microswitches.

3. Developmentally and age-appropriate learning materials.

4. Assessment tools and standardized tests.

5. Expendable materials such as test protocols and adaptive equipment such as Velcro, dycem, foam, or strapping.

6. Office equipment such as files, desks, and resource books.

Assistive technology devices which are considered to be student-specific, necessary to support the student's educational program, and appearing on the

IEP should be procured through the LEA. The student's family and/or residential facility typically provides equipment that is not necessary for educational programming. Various resources exist regarding the identification, procurement and funding of assistive technology including Office of Civil Rights (OCR) statements and Office of Special Education Programs (OSEP) letters; *Assistive Technology: AEA Model Policies and Procedures* (1992); *Iowa Programs Providing and Financing Children's Care and Services* (1994); and the Iowa Program for Assistive Technology (IPAT). Physcial therapists should be knowledgeable of community funding resources and assist the family to obtain equipment as requested.

The therapist may require access to woodworking or maintenance shops in order to construct and adapt equipment needed for student functioning within the educational environment. Equipment which has been created and/or recommended by the physical therapist for educational use with specific students should include documented guidelines for how the equipment is to be used, what type of supervision is required for its use, and documentation of "informed consent" which states the limitations of the equipment's use and liability. The therapist may be held liable if an injury would result from equipment fabricated or recommended by the therapist.

DOCUMENTATION

Documentation is essential for good communication and accountability of the therapist's actions. Part of the initial assessment process and ongoing reassessment includes documentation of the student's current physical status and level of motor functioning so that future changes in performance can be measured. The IFSP and IEP should be used to document the model of service, the amount of therapy service, and modifications needed in general education. Programming strategies may also be included in the IEP. Ongoing monitoring of progress toward goal and objective achievement should be documented according to AEA and LEA procedures. Prior to the annual review of the student's program, the therapist should reassess and document the student's present level of performance.

Progress notes and attendance logs should also be included in the therapist's documentation procedures. The frequency of progress notes should be established by each area education agency. Therapists should be accountable for intervention time as defined in the IFSP or IEP and for information regarding the student's progress. Information should be collected as requested by the area education agency PT supervisor so that annual service reports can be submitted as needed.

SUPERVISION AND EVALUATION

Physical therapy supervisors have the responsibility for the appropriate delivery of educationally related physical therapy services. They should monitor services and conduct formative and informative evaluations to determine need for changes in service delivery procedures, organizational structure, staffing patterns and personnel needs, management of caseloads, budgeting, and procedures for management of records.

Physical therapists should systematically review their own performance. This can include both self-evaluation and peer review. This review should include 1) student-related outcomes and quality of their services, 2) their relationships both within and outside of their disciplines as they affect their performance, and 3) the appropriateness and quality of their management and administrative functions.

Therapists must take an active role in reviewing, evaluating, and updating their discipline's and agency's policies and procedures as they relate to the practice of physical therapy in the educational system. Physical therapists should be aware of state and national trends which might affect delivery of therapy services to students in special education. When requested, on-site visitations by the Department of Education, Bureau of Special Education PT Consultant can provide assistance to AEA supervisors, administrators, and therapists for program evaluation and development.

Physical therapists train and supervise many different personnel as they implement student-specific programs in the educational environment. They also have the legal responsibility for supervising PTAs as they carry out therapy services. The PT is directly responsible for selecting which tasks are to be delegated to other personnel. Therapists must maintain written records of tasks delegated and specific training and supervision of other personnel. The specific activities that are delegated depend upon the therapist's professional judgment; upon the nature of the student's problems; upon the particular interventions to be delegated; and upon the expertise, skill, training, and knowledge of those carrying out the activities.

CONTINUING EDUCATION AND STAFF DEVELOPMENT

Physical therapy licensure laws in Iowa mandate appropriate continuing education. Physical therapists and PTAs are responsible for meeting these requirements. They should work with their respective agencies to identify and meet their individual continuing education needs. Inservice training should be an integral part of professional staff development. The Department of Education's PT Consultant is available for on-site technical assistance and staff training. Area education agency PT staff are encouraged to attend statewide staff development sessions offered through the Department of Education.

INTERAGENCY COLLABORATION

Physical therapists are health professionals, and thus must maintain a close relationship with physicians and other health and human service professionals. The IFSP process mandates this collaboration, but collaboration also needs to occur for all students when appropriate. For example, when a student's medical diagnosis has implications for educational programming, a PT should obtain necessary medical information before proceeding with an assessment or intervention. Appropriately documented written and verbal communication should take place between the therapist and other agencies.

LIABILITY

Many physical therapists carry malpractice insurance. The method of employment (direct-hire or contractual) determines the type of malpractice coverage that may be needed by the therapist. The level and scope of authority within either employment arrangement should be understood and documented by employer and employee. Therapists are personally liable for activities outside of their designated scope of authority.

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APPENDIX A

Physical Therapy Entrance and Exit Criteria Form

Student's Name: _____ **Birth Date:** _____ **Therapist:** _____ **Entrance Date:** _____ **Review Date:** _____	Entrance Criteria					Exit Criteria			
	Problem interferes with student's ability to benefit from his/her educational program.	Problem appears to be primarily motor or sensorimotor based.	As documented, previous attempts to alleviate problems have not been successful.	Therapists unique expertise is required to meet the student's identified needs.	Potential for change in student's problem through intervention appears likely (change unrelated to maturity).	Goals & objectives requiring PT have been met and no additional goals requiring PT are appropriate.	Potential for further change as a result of PT intervention appears unlikely.	Problem ceases to be educationally relevant.	Therapy is contraindicated due to change in medical or physical status.
I. Mobility									
1. Functional Movement Skills									
2. Ability to Handle Arch Requirements									
3. Utilizing Assistive Devices									
4. Transfers									
5. Other (Specify)									
II. Positioning									
1. Independent Sitting/Standing									
2. Assisted Alternative Positions									
3. Transportation									
4. Other (Specify)									

RATIONALE:

This form is to be used to assist in the decision-making process for determining the appropriateness of identifying physical therapy as a support service on a student's IEP or IFSP. It does not delineate which model or amount of service would be most appropriate to help the student benefit from his/her educational program. Those are separate decisions that are made after it is decided that physical therapy is an indicated resource to meet a specific student's goals and objectives. Keep in mind that traditional therapy concerns such as range of motion, strengthening, improving balance, and prevention of contractures may be a means for accomplishing a student's educational goals but are not the goal themselves. Parts of this form will rely on professional judgment following a complete physical therapy assessment.

USE OF ENTRANCE AND EXIT CRITERIA FORM

Directions for Entrance:

Following the therapist's assessment, the student's educational problem(s) should be identified in the categories listed. State educational relevance for every problem area by marking the first column with a "yes" for relevance, "no" if not relevant, or "NA" when it is not an area of concern. Then, for problem areas marked with a "yes," check those additional entrance criteria statements across the row that apply to the student. If ALL five entrance criteria are marked with a "yes," then physical therapy should be considered as a resource to meet the student's IEP or IFSP goal or objective.

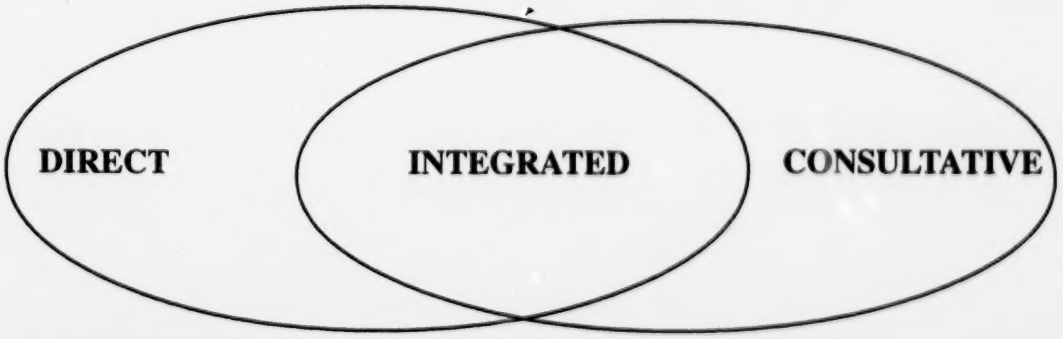
Directions for Exit:

Following student reassessment, check any exit criteria items that apply to previously identified problem areas. When one or more of the exit criteria have been met, the physical therapy services should no longer be considered as a resource to meet the student's IEP or IFSP goal or objective. If new problem areas are identified during this process, complete a new criteria form updating the problem areas.

APPENDIX B

Models of Physical Therapy Service Delivery

	DIRECT	INTEGRATED	CONSULTATIVE
THERAPIST'S PRIMARY CONTACT	• student	• student, teacher, parent, associate	• teacher, parent, associate, student
ENVIRONMENT FOR SERVICE DELIVERY	• distraction free environment (may need to be separate from learning environment) • specialized equipment needed	• learning environment with support of others within that setting • may include a separate environment at times	• learning environment with support of others within that setting
METHODS OF INTERVENTION	• specific therapeutic techniques which cannot be safely delegated • emphasis on acquisition of new motor patterns	• educationally related functional activities • emphasis on practice of newly acquired motor skills in the daily routine	• educationally related activities • assistive technology • adaptive materials • emphasis on accommodations to learning environment
IMPLEMENTER OF ACTIVITIES	• PT, PTA	• PT, PTA • teacher, parent, associate, other school personnel	• teacher, parent, associate, other school personnel



APPENDIX C

Factors to Consider When Deciding on Amount of Physical Therapy Service*

Factors	1	2	3	4
Potential to benefit with therapeutic intervention	Student demonstrates minimal potential for change	Student appears to have potential for change but at a slower rate	Student appears to have a significant potential for change	Student appears to have a high potential to improve skills
Critical period of skill acquisition or regression related to development or disability	Not a critical period	Minimally critical period	Critical period	Extremely critical period
Amount of motor program that can be performed by others in addition to therapist intervention	Motor program can be carried out safely by others with periodic intervention by therapist	Many activities from the motor program can be safely performed by others in addition to intervention by therapist	Some activities from the motor program can be safely performed by others in addition to intervention by therapist	A few activities can be safely performed by others but most of the motor program requires the expertise of the therapist
Amount of training provided by therapist to others carrying out the program	Teacher, staff and/or parents highly trained to meet student's needs. No additional training needed	Teacher, staff and/or parents trained but some follow-up needed	Teacher, staff and/or parents could be trained to carry out some activities	Teacher, staff and/or parents could carry out some activities with extensive training
Amount motor problem plus environment interferes with educational program	Environment is accommodating and motor difficulties are minimal	Environment is accommodating and motor difficulties are moderately interfering	Environment is accommodating but motor difficulties are significant	Environment is not accommodating; or environment is accommodating but

*For complete instructions for utilization of this form, refer to the *Resource Manual for Physical and Occupational Therapists*, 1990 and revisions.